Atrium Health Infusion Centers
Phone: 704-468-3400 Fax: 704-468-3401

Thiamine Infusion Order

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: Prior to first infusion TDP level if available (If outside of Atrium, fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Thiamine _____ mg IV over 30mins **ICD 10 code: _____**

☐ **Frequency:** _____ days

PRN Medications:

☐ Acetaminophen ____ mg PO x 1

☐ Benadryl _____ mg PO or ____ mg IV x 1 *(if applicable, only choose ONE)*

☐ Loratadine 10 mg PO x 1

☐ SoluMedrol _____ mg IV x 1

Additional Orders:

_____

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion.
- Monitor for signs of reaction for 30 mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed

Provider Name: _____
Provider Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: